

PRESUMPTIVE ELIGIBILITY
PATIENT INFORMATION FORM

PLEASE COMPLTE & RETURN TO YOUR HOSPITAL'S OFFICE STAFF

Your Social Security Number

____-____-____

Today's Date

__/__/____

Date of Birth : __/__/____

Age: ____

Your Name:

Last Name

First Name

M.I.

Do you Receive Medicaid? ☐ Yes ☐ No

Your Address:

Street Address

Apt./Building Number

City

State

Zip Code

County

Telephone Numbers:

(____) ____ - ____

Home

(____) ____ - ____

Work

Marital Status (check one):

☐ Married

☐ Single

Race:

☐ White

☐ Asian

☐ Black

☐ American Indian ☐ Other

Number of People in My Family: ____*

*Count number of unborn if anyone in family pregnant.

FAMILY INCOME (use separate sheet if necessary)

	Family Member's Name	Income Type	How Much?**	How Often?
1				
2				
3				
4				
5				

Total Income: _____

**Income counted is before taxes are taken out.

Employer Information – complete only if income is from wages.

Line #	Employer Name	Employer Address

Other Insurance:

Do you have other insurance that covers healthcare provider visits or hospital services? ☐ Yes ☐ No

If yes:

Name of Insurance Co.

Policy No.

Group No.

I certify, under penalty of perjury, the information provided by me in this statement is correct and true to the best of my knowledge. I understand that anyone who gives false information in order to receive benefits, or lets someone else use their PE card or abuses PE benefits is subject to criminal action under federal law, state law or both or may be liable for repaying in cash the value of the benefits received.

Signature

Date Signed